MEDI-CAL UPDATE Part 2
Billing and Policy
www.medi-cal.ca.gov

Pharmacy

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Contents

Medi-Cal Claim Form Changes May 23, 2007; Transition from Current Form Begins March 26

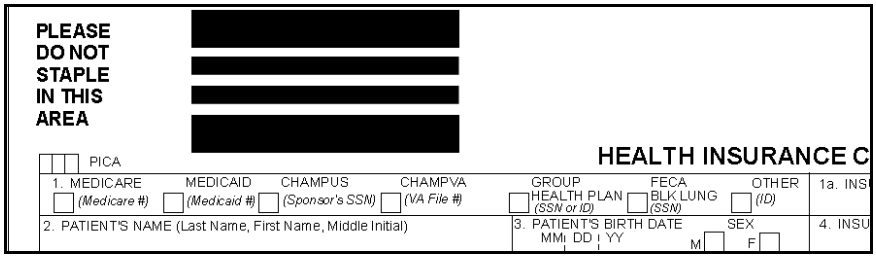
Effective May 23, 2007, the California Department of Health Services (CDHS) will complete a transition from the current *HCFA 1500* claim form to the new *CMS-1500* claim form. Beginning March 26, 2007, providers will have a two-month transition period in which they can use both the new and old form to submit claims. The transition period ends at the close of business on May 22, 2007. Beginning May 23, 2007, only the *CMS-1500* will be accepted for Medi-Cal billing.

All boxes mentioned below are only updates to the new form. Not all new and updated boxes must be filled in for proper billing and payment. New claim form billing instructions will be published in the appropriate Part 2 provider manual in May 2007.

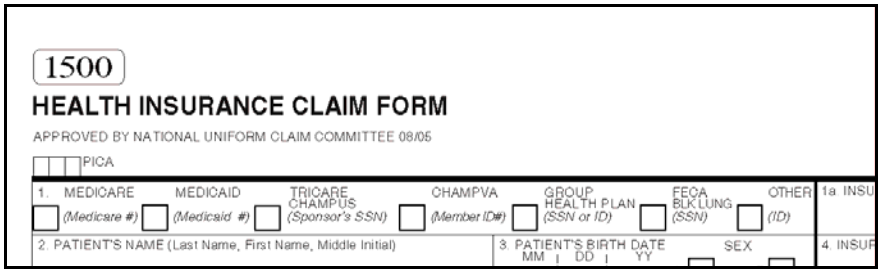
Also, providers using the new forms must continue to use their Medi-Cal provider number until May 23, 2007.

Below are the changes from the current *HCFA 1500* to the new *CMS-1500* claim form.

Header and Box 1:
Old Form



New Form

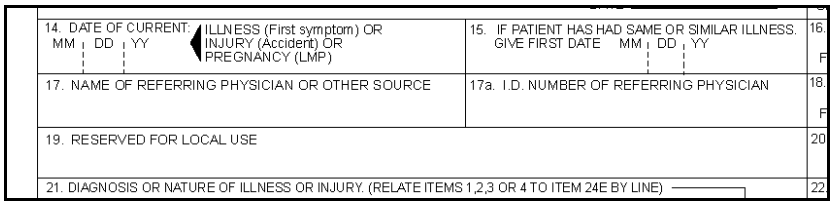


At the top of the page: 1) the barcode has been removed, 2) the language "Please Do Not Staple In This Area" has been removed, and 3) a box with "1500" is added in black ink. In Box 1, "Tricare" was added above "Champus."

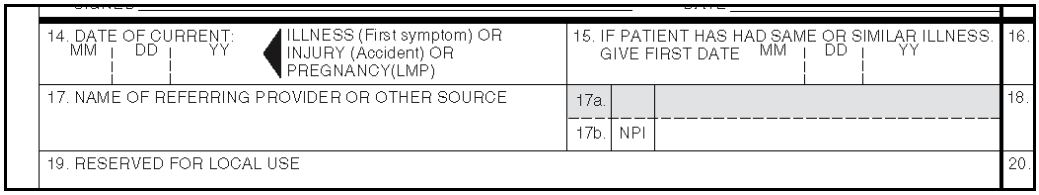
Please see **Claim Form**, *page 2*

Claim Form *(continued)*

Box 17
Old Form

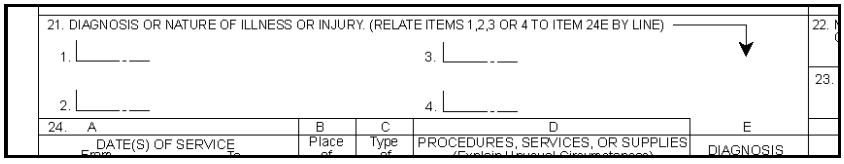


New Form

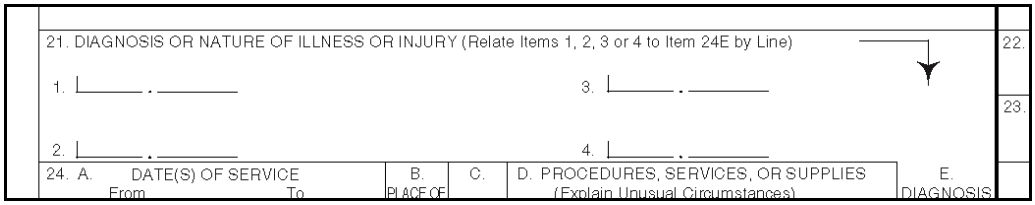


The name of Box 17 was changed to "Name of Referring **Provider** or Other Source." Box 17A ("ID Number of Referring Physician") was removed. The *NPI* field (Box 17B) was added.

Box 21 (Diagnosis of Illness or Injury)
Old Form



New Form



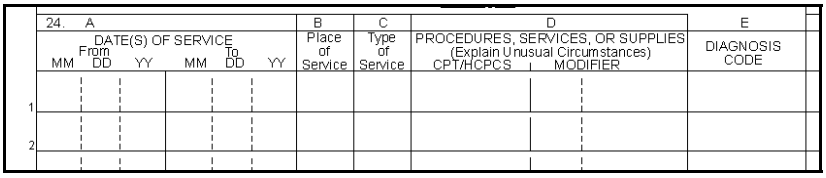
The spaces after the decimal point in items 1, 2, 3 and 4 were extended to accommodate future changes in diagnosis codes.

Please see **Claim Form**, *page 3*

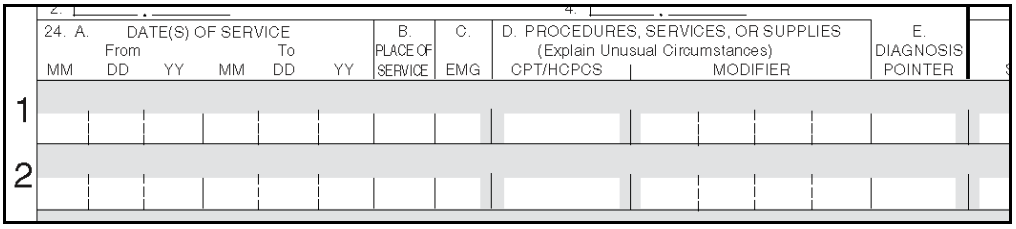
Claim Form *(continued)*

Boxes 24A – 24E

Old Form



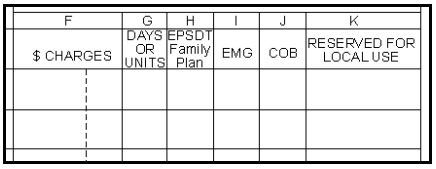
New Form



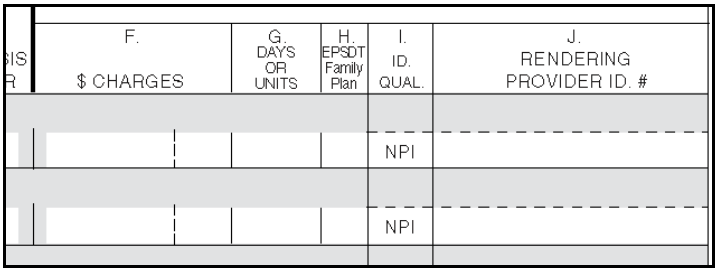
The lines are split length-wise, with shading added to the top portion of each line. The shaded area is used for the reporting of supplemental information. Information submitted in the shaded area must stay within the shaded area to process correctly. The name of Box 24C was changed to "EMG." This is the new location for emergency and delay reason codes.

Boxes 24I – 24K

Old Form



New Form

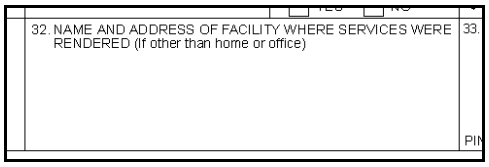


The name of box 24I was changed to "ID Qual." The name of Box 24J was changed to "Rendering Provider ID #" and the unshaded area was named "NPI." The rendering provider's National Provider Identifier (NPI) must be reported in the unshaded box. Also, Box 24K ("Reserved for Local Use") was removed.

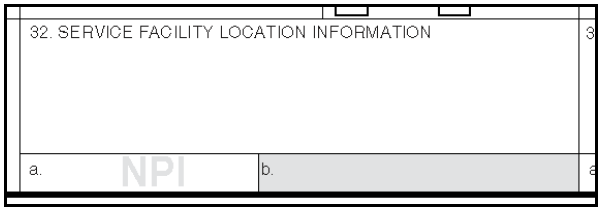
Please see **Claim Form**, *page 4*

Claim Form *(continued)*

Box 32
Old Form



New Form



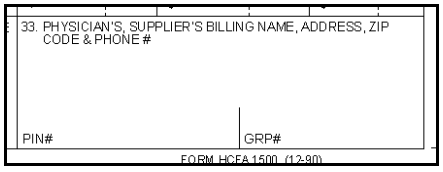
Box 32 was renamed "Service Facility Location Information." Boxes 32A and 32B were added at the bottom. Box 32A was added to accommodate reporting of the facility NPI. Box 32B was added to accommodate reporting of an "atypical" facility provider number.

Note About Atypical Providers:
In accordance with the NPI final rule, some providers may not qualify for an NPI and therefore are not required to register an NPI with the Medi-Cal program. According to CDHS' interpretation of the final rule as it relates to atypical providers, the following Medi-Cal provider types below are <u>not</u> required to register an NPI:

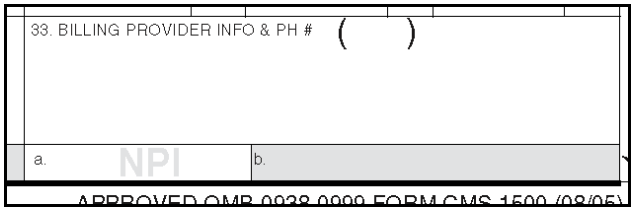
- Adult Day Health Care (ADHC) Centers
- Blood Banks
- Christian Science Practitioner
- Multipurpose Senior Services Program (MSSP)

If any of the above provider types acquire an NPI, they may register it with the Medi-Cal program, but it is not required.

Box 33
Old Form



New Form



Box 33 was renamed "Billing Provider Info & Phone Number." Boxes 33A and 33B were added at the bottom. Box 33A was added to accommodate reporting of the billing provider's NPI. Box 33B was added to accommodate reporting of an atypical provider number.

Universal Product Number (UPN) Pilot Ready for Participants

Request to Participate
The California Department of Health Services (CDHS) is pleased to announce that the *Request to Participate in the Universal Product Number (UPN) Pilot* form is now available. The UPN pilot is open to Pharmacy and Durable Medical Equipment (DME) providers who are currently enrolled in Medi-Cal in good standing and are already authorized to provide medical supplies to Medi-Cal recipients.

In order to participate in this pilot, providers must comply with all of the following requirements in addition to the usual Medi-Cal requirements:

1. Include UPNs on electronic or paper medical supply claims for certain covered products dispensed between January 1, 2008 and December 31, 2009.
2. Abide by all Medi-Cal electronic and paper claim submission requirements as instructed in the Medi-Cal provider manual for medical supply claims.
3. Comply with all provider manual updates and provider bulletins relating to the UPN pilot.
4. Promptly advise CDHS in writing of any changes in provider or biller status, which might affect eligibility to participate in the UPN pilot billing pursuant to federal and state law.
5. Comply with all the terms and conditions set forth in the *Medi-Cal Provider Agreement* and the *Medi-Cal Telecommunications Provider and Biller Application/Agreement* or as otherwise required by state or federal law or regulation.

CDHS will select participating providers based on geographic location and claim volume. Providers who submit a *Request to Participate in the Universal Product Number (UPN) Pilot* form will be notified of eligibility in writing within 45 days.

Providers may download and print a copy of the *Request to Participate in the Universal Product Number (UPN) Pilot* form from the Medi-Cal Web site **(www.medi-cal.ca.gov)**. To locate the form, click the "UPN" link on the Medi-Cal Web site home page and then click "*Request to Participate in the Universal Product Number (UPN) Pilot*." Please print, complete, sign and mail to the address listed on the form or fax it to the UPN Pilot Office/HIPAA Team at (916) 638-8976.

Termination
CDHS or the provider may terminate a provider's participation in this pilot, with or without cause, by giving 30 days prior written notice of intent to terminate.

Additional Information
Specific information regarding product categories and medical supplies can be found in the "UPN" area of the Medi-Cal Web site, which includes Frequently Asked Questions (FAQs). Details will continue to be published in the monthly *Medi-Cal Updates* and the provider manual.

For more information regarding the completion of the *Request to Participate in the Universal Product Number (UPN) Pilot* form or the UPN pilot, contact the Telephone Service Center at 1-800-541-5555, from 8 a.m. to 5 p.m., Monday through Friday. Software vendors and out-of-state billers may call (916) 636-1200.

Family PACT Formulary Update

Effective for dates of service on or after January 16, 2007, Family PACT (Planning, Access, Care and Treatment) is adding oral contraceptive pills to the Family PACT Pharmacy Formulary for dispensing by pharmacies and clinicians. Clinicians must bill these contraceptives using HCPCS code X7706 (oral contraceptive medication).

The following drugs and strengths are added as Family PACT Pharmacy Formulary benefits for Pharmacy providers and clinicians:

- Drospirenone/Ethinyl Estradiol (Yaz tablets) – The 28-day treatment cycle consists of 24 active tablets, each containing 3 mg of drospirenone and 0.02 mg of ethinyl estradiol, as well as four inert tablets.
- Norethindrone/Ethinyl Estradiol/Ferrous Fumarate (Femcon 35 Fe chewable tablets) – The 28-day treatment cycle consists of 21 tablets, each containing 0.4 mg of norethindrone and 0.035 mg of ethinyl estradiol, as well as seven placebo tablets, each containing 75 mg of ferrous fumarate.
- Norethindrone Acetate/Ethinyl Estradiol/Ferrous Fumarate (Loestrin 24 Fe) – The 28-day treatment cycle consists of 24 tablets, each containing 1 mg of norethindrone acetate and 0.02 mg of ethinyl estradiol, as well as four placebo tablets, each containing 75 mg of ferrous fumarate.

The following contraceptive has been added as a Family PACT benefit and may be dispensed by Pharmacy providers only:

- Levonorgestrel/Ethinyl Estradiol (Seasonique tablets) – The 91-day treatment cycle consists of 84 active tablets, each containing 0.15 mg of levonorgestrel and 0.03 mg of ethinyl estradiol, as well as seven tablets, each containing 0.01 mg of ethinyl estradiol.

Revised *Family PACT Policies, Procedures and Billing Instructions* (PPBI) manual pages will be issued in a future mailing to Family PACT providers. For more information about Family PACT, call the Telephone Service Center (TSC) at 1-800-541-5555 from 8 a.m. to 5 p.m. Monday through Friday, except holidays, or visit the Family PACT Web site at **www.familypact.org**.

Annual Family PACT Updates and Policy Clarification

Effective for dates of service on or after February 1, 2007, the following CPT-4 code information is updated to reflect current Family PACT Program policy. These updates affect billing requirements and restrictions but do not expand program benefits.

CPT-4 Code Additions
The following CPT-4 codes are added to the Family PACT Program:

Code	Description
58110	Endometrial sampling (biopsy) done in conjunction with colposcopy
78456	Acute venous thrombosis imaging
90760	Intravenous infusion, hydration, up to one hour
90761	Intravenous infusion, additional hours
99144	Moderate sedation, first 30 minutes
99145	Moderate sedation, each additional 15 minutes

Please see **Family PACT Updates**, *page 7*

Family PACT Updates *(continued)*

CPT-4 Code Restriction Modifications
Code 58110 is restricted to females, 15 to 55 years of age, when clinically indicated for the follow-up of a Pap smear result finding atypical glandular cells (ICD-9-CM 795.00) and any of the following:

- Atypical endometrial cells, or
- A recent history of abnormal vaginal bleeding pattern suspicious for endometrial hyperplasia or cancer, or
- Recipient is 36 to 55 years of age

This procedure is reimbursable to non-physician medical practitioners. The procedure is payable for all primary diagnosis codes except S60 and S80. A secondary diagnosis code of 795.00 is required or the claim will deny.

Code 78456 is restricted to females. A primary diagnosis code of S1031 and an approved *Treatment Authorization Request* (TAR) are required or the claim will deny.

Codes 90760 and 90761 are restricted to females. The procedure is payable only for primary diagnosis code S2031 or S3035 and requires an approved TAR. The claim must include documentation that a physician administered or supervised the procedure.

Code 99144 is restricted to females 21 to 55 years of age with a primary diagnosis code of S702 and to males 21 to 60 years of age with a primary diagnosis code of S802.

Code 99145 is billed only in conjunction with 99144. It is restricted to females 21 to 55 years of age with a primary diagnosis code of S702 and to males 21 to 60 years of age with a primary diagnosis code of S802.

Code 58100 (endometrial sampling, with or without endocervical sampling, without cervical dilatation, any method, separate procedure) is restricted to females 40 to 55 years of age with a finding of endometrial cells on Pap and a recent history of menstrual irregularity. A secondary diagnosis of 795.09 (other abnormal Pap) is required on the claim or the claim will deny.

CPT-4 Code Deletions
Codes 78455, 90780, 90781 and 99141 are no longer active and are deleted as Family PACT Program benefits.

"Family PACT Program 2006 Provisional Clinical Services Benefits Grid"
The "Family PACT Program 2006 Provisional Clinical Services Benefits Grid" presents the benefits package codes for procedures, medications and contraceptive supplies. Code 58110 is added to the benefits package effective February 1, 2007.

The following information replaces the 9th page of the Family PACT Provisional Services Benefits Grid (see June 2006 *Medi-Cal Update* Part 2 bulletin). The bulletin page number to be replaced will vary depending on which bulletin the provider received.

Please see **Family PACT Updates**, *page 8*

Family PACT Updates *(continued)*

Secondary Diagnosis: Cervical Abnormalities

A secondary diagnosis code is required for cervical abnormality diagnostic and treatment services. These services are restricted to females 15 to 55 years of age.

Other Secondary Services						Complications Services (10)
Diagnosis Codes	**Description**	**Procedures**	**Laboratory**	**Supplies**	**Medications**	**Description**
ICD-9-CM 795.01 795.02 795.03 795.04 795.05 622.2	 ASC-US Pap ASC-H Pap LGSIL Pap HGSIL Pap Abn Pap with HPV high risk pos. Presumptive Dx. Leukoplakia, cervix	57452 Colposcopy 57454 Colpo with biopsy & ECC 57455 Colpo with biopsy 57456 Colpo with ECC	• 87621 DNA Amplified Probe HPV High Risk Only (18) • 88305 Surgical pathology	57452ZM Supplies 57454ZM Supplies 57455ZM Supplies 57456ZM Supplies	None	Pelvic infection resulting from cervical treatment Hemorrhage from cervical biopsy or treatment site requiring surgical repair Vaso-vagal episode
795.00	AGC Pap	57452 Colposcopy 57454 Colpo with biopsy & ECC 57455 Colpo with biopsy 57456 Colpo with ECC 58110 Endometrial biopsy (19)	• 88305 Surgical pathology	57452ZM Supplies 57454ZM Supplies 57455ZM Supplies 57456ZM Supplies 58100ZM Supplies	None	
622.11 622.12 233.1	CIN I (biopsy) CIN II (biopsy) CIN III (biopsy)	57452 Colposcopy 57454 Colpo with biopsy & ECC 57455 Colpo with biopsy 57456 Colpo with ECC 57511 Cryocautery of cervix (16) 57460 LEEP (16)	• 87621 DNA Amplified Probe HPV High Risk Only (18) • 88305 Surgical pathology • 88307 Surgical pathology (17)	57452ZM Supplies 57454ZM Supplies 57455ZM Supplies 57456ZM Supplies 57511ZM Supplies 57460ZM Supplies	None	
795.09	Other abnormal Pap	58100 Endometrial biopsy (20)	• 88305 Surgical pathology			

(10) Complication services for a secondary diagnosis require a primary diagnosis (Sxx.3) and a TAR – see *Family PACT: Treatment Authorization Request (TAR).*

(16) Restricted to biopsy proven CIN II or CIN III or persistent CIN I lesions of greater than 12 months.

(17) Restricted to biopsy specimens collected by LEEP procedure.

(18) DNA Amplified Probe HPV (High Risk Only) is covered in the following circumstances (see ASCCP, Guidelines 2002) and limited to one per year per client:

- Reflex HPV DNA testing after an ASC-US cytology result.
- Follow-up of LSIL cytology result in women less than 21 years of age. HPV DNA testing at 12 months in lieu of cytology at 6 and 12 months.
- Follow-up post-colposcopy; Women with Paps read as ASC-H, LSIL, or HPV DNA positive ASC-US in whom CIN is not identified at colposcopy can be followed up at 12 months with HPV DNA testing in lieu of cytology at 6 and 12 months.
- Follow-up of women with biopsy proven untreated CIN I; HPV DNA testing at 12 months in lieu of cytology at 6 and 12 months.
- Follow-up post treatment of CIN II, III: HPV DNA test at least six months after treatment in lieu of follow-up cytology.

DNA Amplified Probe HPV testing is not covered for a diagnosis of HGSIL Pap, ICD-9-CM 795.04 or Leukoplakia cervix, ICD-9-CM 622.2.

(19) Endometrial biopsy is covered only if AGC (atypical glandular cells) cytology result and any of:

- "Atypical endometrial cells" on AGC cytology result.
- Woman is having abnormal vaginal bleeding pattern suspicious for endometrial hyperplasia or cancer.
- Woman is 36 through 55 years of age.

(20) Endometrial biopsy restricted to women aged 40 years or older with a finding of endometrial cells on Pap and a recent history of menstrual irregularity.

Please see **Family PACT Updates**, *page 9*

Family PACT Formulary Update
The following policy clarifications correct errors in the printed version of the Family PACT Pharmacy Formulary only. Online adjudication of pharmacy claims is not affected.

The following formulations are not available:

- Norethindrone and ethinyl estradiol 1 mg – 20 mcg tablets from 28 tablet pack
- Norethindrone and ethinyl estradiol 1.5 mg – 30 mcg tablets from 28 tablet pack

Corrected dosage information:

- Norelgestromin and ethinyl estradiol Transdermal Patch is 0.15mg/20mcg/day.
- Etonorgestrel and ethinyl estradiol Vaginal Ring is 0.120mg/15mcg/day.

Permanent Contraception (Sterilization) Policy clarifications
Postoperative core services refer to the routine care associated with a surgical procedure, including routine postoperative care. Services for the management of complications are not core services. Related reproductive health services are not routine postoperative care. This policy applies to services for both female and male recipients.

Postoperative core services are provided during the global period defined for the surgical procedure. The global period is 90 days for surgical procedure codes 55250, 58600, 58615, 58670 and 58671.

At the end of the 90-day post-operative period, or earlier as determined by the clinician, sterilized clients are no longer eligible for the Family PACT Program. This clarification applies to both female and male recipients that have elected permanent contraception.

Revised *Family PACT Policies, Procedures and Billing Instructions* (PPBI) manual pages will be issued in a future mailing to Family PACT providers. For more information about Family PACT, call the Telephone Service Center (TSC) at 1-800-541-5555 from 8 a.m. to 5 p.m. Monday through Friday, except holidays, or visit the Family PACT Web site at **www.familypact.org**.

Infusion Equipment Treatment Authorization Request (TAR) Clarification

To avoid processing delays, all *Treatment Authorization Requests* (TARs) for infusion equipment, including pumps, supplies and related equipment, must be submitted to the Fresno Medi-Cal Field Office. TARs submitted to either of the Pharmacy Sections will be forwarded to the Fresno Medi-Cal Field Office.

Documentation Requirements for TARs
TARs for infusion equipment must include a copy of a signed prescription from a licensed practitioner who is acting within his or her scope of practice as established by *California Code of Regulations* (CCR), Title 22, Section 51321, along with medical justification demonstrating that the item selected is appropriate for a recipient's medical needs.

A TAR for an enteral or I.V. pump requires the following documentation:

- Diagnosis
- Type of pump
- Rental or purchase item
- Medical reason why pump is indicated for this medication or formula

Please see **Infusion Equipment**, *page 10*

Infusion Equipment *(continued)*

A TAR for enteral and infusion supplies requires the following documentation:

- Diagnosis
- Description of how requested item is expected to improve or stabilize the recipient's medical status
- Estimated length of time the item will be medically necessary
- Rate of infusion
- Frequency of infusion
- Delivery system: gravity, bolus or pump

A TAR for non-formulary items requires the following documentation:

- Description of what formulary items have been tried and failed
- Medical reason(s) why formulary item cannot be used

Prescription Information Requirements
If the prescription lacks the required information, the TAR may be deferred for additional documentation. Providers may wish to send a prescription to the licensed practitioner for documentation of medical necessity.

All prescriptions must contain the following information:

- Recipient's name and 14-character Benefits Identification Card (BIC) ID number
- Medication, infusion rate and frequency
- Physician's signature, printed name and address
- Date prescription was signed

Prescriptions for I.V. pumps and/or supplies must contain the following information:

- Verification that I.V. pump is medically necessary (including reason why medication cannot be administered by gravity or bolus)
- Number of days I.V. pump rental is needed
- Indication if I.V. pump purchase is required for long-term use
- List of supplies required monthly for use with purchased I.V. pump

Prescriptions for enteral pumps and/or supplies must contain the following information:

- List of formula, infusion rate and frequency
- Verification that enteral feeding pump is medically necessary (include reason why formula cannot be administered by gravity or bolus)
- Number of days enteral pump rental needed
- Indication if enteral pump purchase required for long-term use
- List of supplies required monthly for use with purchased enteral pump
- Reason why non-formulary G tube is medically necessary

Updated information is reflected on manual replacement page mc sup intro 1 (Part 2).

Negative Pressure Wound Therapy Policy Update

Effective for dates of service on or after November 1, 2006, policy for Negative Pressure Wound Therapy (NPWT) HCPCS codes is modified as follows:

- Pump: Code E2402 is limited to one per 120-day period.
- Canisters: Codes A7000 (disposable) and A7001 (non-disposable) no longer require claim documentation that they are for equipment that is owned by the patient. These codes must be billed with modifier NU (purchase) only.
- The frequency limitation for code A7000 is changed from 1 per month to 10 per month. All may be dispensed on the same date of service.

This information is reflected on manual replacement pages dura 10 (Part 2), dura bil dme 23 (Part 2) and dura cd fre 1 (Part 2).

Updated Benefit Status of Select Drug and Medicine Codes

Effective February 1, 2007, HCPCS code J3490 (unclassified drugs) is a Medi-Cal benefit and should be used instead of CPT-4 codes 90399 and 90749. Effective February 1, 2007, CPT-4 codes 90399 (unlisted immune globulin) and 90749 (unlisted vaccine/toxoid) are no longer benefits.

HCPCS code J3490 is to be reimbursed "By Report" and an invoice is required. When billing code J3490, providers must include a diagnosis code and document the following in the *Reserved for Local Use* field (Box 19) of the claim:

- Medical necessity for using the drug
- Name, dosage, strength and unit price of the medication

HCPCS code J3590 (unclassified biologics) requires a *Treatment Authorization Request* (TAR) and must be billed with an invoice for pricing. Providers must also document the following on the TAR:

- Medical necessity for using the drug
- Name, dosage, strength and unit price of the medication

Note: Providers should use codes J3490 and J3590 only if an appropriate injection code is not found.

This information is reflected on manual replacement pages inject 2 and 3 (Part 2).

Fixed Patient Lift System Non-Benefit

Effective February 1, 2007, HCPCS code E0640 (patient lift, fixed system, includes all components/accessories) will no longer be a reimbursable code for California Children's Services (CCS) clients.

This information is reflected on manual replacement page dura cd ccs 1 (Part 2).

DME Frequency Limit Update

Effective retroactively for dates of service on or after November 1, 2006, the frequency limit for HCPCS code E2215 (manual wheelchair accessory, tube for pneumatic caster tire, any size, each) is two in six months.

This information is reflected on manual replacement page dura cd fre 3 (Part 2).

Non-Physician Medical Practitioners Furnishing or Ordering Drugs or Devices

Providers are reminded of the current policy for the handling of prescriptions for drugs or devices written by Non-Physician Medical Practitioners (NMPs).

Nurse Practioners (NPs) and Certified Nurse Midwives (CNMs) can furnish or order drugs or devices in accordance with standardized procedures or protocols under the supervision of a physician who has current practice or training in the relevant field. Such supervision does not require the physical presence or the co-signature or countersignature of the physician on prescriptions.

Additional information about NMPs is available on the Medi-Cal Web site (**www.medi-cal.ca.gov**). Under "Provider Manuals," click "Medical Services," then "Part 2 – General Medicine (GM)" and then *Non-Physician Medical Practitioners (NMP).*

This information is reflected on manual replacement page dura 4 (Part 2).

Instructions for Manual Replacement Pages — Part 2

January 2007

Pharmacy Bulletin 646

Remove and replace:	*Contents for Pharmacy Billing and Policy v/vi* * dura 3/4, 9/10 dura bil dme 23/24 dura cd ccs 1 dura cd fre 1 thru 4 inject 1 thru 4 mc sup intro 1/2 presum 17/18 *
Insert new section after the *Why You Cannot Get Presumptive Eligibility Benefits* form:	prov bil 1 thru 4 *
Insert after the new *Provider Billing after Beneficiary Reimbursement (Conlan v. Shewry)* section above:	*Request for Beneficiary Reimbursement Letter (Letter 08)* *

* Pages updated due to ongoing provider manual revisions.